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Supreme Court, U.S.
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IN THE OFFICE OF THE CLERK

Supreme Court of the United States

EVELYN ORTIZ as Personal Representative of the Estate of Rafael I. Ortiz-Pagan,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

In this Federal Tort claim for the wrongful death by suicide of Petitioner EVELYN ORTIZ's husband at the V.A. Hospital in Gainesville while he was an involuntary psychiatric patient, the United States District Court, Northern District of Florida rejected Petitioner Ortiz's medical expert's testimony as to the Standard of Care and causation and entered judgment in favor of the United States of America despite the failure of the United States to present any expert testimony, or any medical evidence, other than the testimony of the V.A. doctors responsible for Mr. Ortiz's suicide who testified in direct contradiction to the contemporaneously written medical records. Subsequently, the Eleventh Circuit affirmed and declined reconsideration and reconsideration *en banc*.

1. Whether the failure of the Respondent United States to present any expert testimony on the issues of Standard of Care and proximate causation, coupled with the failure of the Respondent United States to either impeach Petitioner Ortiz or any of her witnesses including her medical (psychiatric) expert or to present other evidence creating a direct conflict to Petitioner ORTIZ's evidence precludes the finding of fact and conclusions of law by the trial court that the Standard of Care owed Petitioner Ortiz's husband was not breached and that the breach of the Standard of Care by the Respondent United States was not the direct and proximate cause of Petitioner Ortiz's husband's suicide.

2. Whether the Eleventh Circuit incorrectly held that the United States District Court Judge is free to reject the testimony of Petitioner ORTIZ's expert (psychiatrist) when the United States failed to present expert testimony, failed to impeach ORTIZ or her expert and only called the doctors at fault who's testimony (credited by the Trial Court) was in direct contradiction to the written contemporaneous medical records.

OPINION BELOW

On November 9, 2009, the United States Court of Appeals in the Eleventh Circuit affirmed the United States District Court's Judgment in favor of the Defendant United States. A Petition for Rehearing and Petition for Rehearing *En Banc* was filed and a denial was issued on March 24, 2010. Mandate was issued on April 1, 2010.

STATEMENT OF JURISDICTION

This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Federal Tort Claim's Act, 28 U.S.C. § 2671, *et seq.*; Florida Statues § 766.102(1) and § 766.102(5) (2006).

STATEMENT OF THE CASE

On December 17, 2004, Petitioner, EVELYN ORTIZ, (EVELYN ORTIZ) as Personal Representative of the Estate of Rafael I. Ortiz-Pagan, under the Federal Tort Claims Acts' (FTCA) statutory scheme 28 U.S.C. § 2675 filed a written claim for damages, injury or death with the Veterans Administration (V.A.) arising out of her husband's suicide while he was an involuntary patient confined to lock down on the psychiatric ward at the Veterans Affairs Hospital located in Gainesville, Florida

(hereinafter the Gainesville V.A. Hospital) because he was dangerous to himself or others. The V.A. denied the claim on or about June 28, 2006.

On December 27, 2006, EVELYN ORTIZ, as Personal Representative of the Estate of Rafael I. Ortiz-Pagan, (hereinafter Evelyn Ortiz) filed suit pursuant to the FTCA, 28 U.S.C. § 2671, *et seq.*, against the United States for the wrongful death by suicide of Rafael I. Ortiz-Pagan, an involuntary patient under lock down on the psychiatric ward at the Gainesville V.A. Hospital. A non-jury Trial was held February 25 and 26, 2008 before the Honorable Stephan P. Mickle, United States District Judge. At trial, EVELYN ORTIZ, as required by Florida Law [Florida Statutes §§ 766.102(1) and 766.102(5)], called an expert witness to establish the Standard of Care and causation. EVELYN ORTIZ's expert (a psychiatrist) testified regarding the Standard of Care, a number of breaches of the Standard of Care by the Gainesville V.A. Hospital, and causation. After EVELYN ORTIZ rested, the United States failed to call any expert witnesses on the issues of Standard of Care or causation. The only evidence presented by the United States was the testimony of the two doctors responsible for the suicide of EVELYN ORTIZ's husband. Both doctors gave testimony in direct contradiction to the contemporaneously kept medical records of the Gainesville V.A. Hospital, and repudicated documents, such as Mr. Ortiz's involuntary commitment papers, completed and signed by one of those doctors (Florida Law recognizes a higher Standard of Care for patients involuntarily committed to a Psychiatric Facility). On September 22, 2008, the court issued a Memorandum of Decision finding that the United States was not liable

for the suicide death of RAFAEL I. ORTIZ-PAGAN, while he was involuntarily committed to the psychiatric ward at the Gainesville V.A. Hospital. The Clerk of Court entered a Judgment in favor of the United States and against EVELYN ORTIZ, as personal representative of the Estate of Rafael I. Ortiz-Pagan. An appeal to the U.S. Court of Appeals for the Eleventh Circuit was filed. On November 30, 2009, the Appellate Court entered its Opinion affirming the decision of the trial court and then denied rehearing and rehearing *en banc*.

REASONS FOR GRANTING THE PETITION

The failure of the Respondent, UNITED STATES, to meet its burden of going forward by failing to present any expert testimony on the issues of Standard of Care and proximate causation, coupled with the failure of the Respondent UNITED STATES to impeach Petitioner ORTIZ's psychiatric expert; or to present other evidence creating a direct conflict of evidence other than the testimony of the two doctors responsible for the suicide of Petitioner ORTIZ's husband, who testified in direct contradiction to the contemporaneous written medical records precludes finding of fact and conclusions of law by the trial court that the Standard of Care owed Petitioner ORTIZ's husband was not breached and that the breach of the Standard of Care by the Respondent UNITED STATES was not the direct and proximate cause of Petitioner ORTIZ's husband's ability to commit suicide.

The Eleventh Circuit's opinion directly conflicts with *Hicks v. United States of America*, 368 F.2d 626 (4th Cir 1966) regarding the Standard of Review in the absence of conflicting experts.

CONCLUSION

For the reasons stated, the Court should grant the petition.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT FILED APRIL 1, 2010

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 08-16004

EVELYN ORTIZ, as Personal Representative of the Estate of Rafael I. Ortiz-Pagan,

Plaintiff-Appellant,

versus

UNITED STATES OF AMERICA,

Defendant-Appellee.

Appeal from the United States District Court for the Northern District of Florida

(November 30, 2009)

Before BLACK, WILSON and COX, Circuit Judges.

Appendix A

COX, Circuit Judge:

I. BACKGROUND

On Monday, March 17, 2003, Rafael Ortiz-Pagan presented to the emergency room at the Department of Veterans Affairs Hospital in Gainesville, Florida ("the hospital" or "the VA"). Ortiz was a chronic pain patient and had overdosed on his pain medication. The emergency room physician kept Ortiz in the emergency room overnight and ordered a psychiatry consult. The psychiatry resident physician who examined and interviewed Ortiz in the late morning on Tuesday, March 18, invoked The Florida Mental Health Act to involuntarily commit Ortiz to the psychiatric ward of the hospital and placed him on suicide precautions.

Ortiz spent much of the day on Tuesday, March 18, on suicide precautions, in the day room of the psychiatric ward, under constant one-on-one observation by a nurse. During that time, he was evaluated by a staff psychiatrist, Dr. Camilo Martin. In the early afternoon, Martin concluded that Ortiz did not require suicide precautions and downgraded his observational status to close observation. On close observation, patients are assigned a room and observed by a nurse at fifteen-minute intervals.

During the afternoon of March 18, both before and after he had been downgraded to close observation status, Ortiz visited with his wife and sons in the day room of the psychiatric ward. After he was changed to

close observation status, the nursing staff checked on him every fifteen minutes. His family departed after 8:00 p.m. Ortiz went to his room and laid in bed. The room Ortiz occupied had several patient beds separated by partitions. There were three other patients in the room. Ortiz was assigned the third bed on the left, a corner bed by a window.

At 11:45 p.m., Ortiz was observed in his bed. At 12:03 a.m. on Wednesday, March 19, 2003, a nurse found Ortiz hanging from a bed sheet attached to the window.[1] He had committed suicide.

Ortiz's widow ("Plaintiff") brought this lawsuit against the United States under the Federal Tort Claims Act, 28 U.S.C. §§ 1346 & 2671-80, alleging that the hospital staff had been negligent in failing to adequately care for and supervise Ortiz. (R.1-1.) At trial, Plaintiff presented expert testimony from Dr. Gary Jacobson. Jacobson had reviewed Ortiz's medical records and opined that hospital personnel breached the standard of care by negligently failing to conclude that Ortiz was a suicide risk. He further opined that, as a result of the

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1. There was no evidence as to how Ortiz attached the bed sheet to the window, or whether the window was open. The only evidence about the physical state of the window was: (1) a nurse's note that, when he found Ortiz hanging at 12:03 a.m. on March 19, 2003, "a white sheet . . . was wrapped around [Ortiz's] neck and attached to the top of the window." (R.5 at 33 INP); and (2) testimony by a nursing assistant on the psychiatric ward that the window by Ortiz's bed was big and square and required a key for opening. (R.3-82 at 60.)

failure to recognize Ortiz was at risk for suicide, the hospital staff failed to monitor Ortiz adequately and failed to place him in an environment that would prevent his suicide. The United States did not present an independent expert witness to rebut Jacobson's testimony. The treating physicians and nurses who interacted with Ortiz on the psychiatric ward testified about their examinations and interactions with him, their assessment of his medical condition, and the actions they took during his hospital stay.

The district court issued a memorandum of decision. The court rejected Jacobson's opinions that the hospital staff had breached the standard of care, offering as an general explanation: "Dr. Jacobson's testimony and his conclusions about Mr. Ortiz were based entirely upon entries in the medical records, some of which were taken out of context and which were later explained in more detail in testimony from treating psychiatrists and nurses." (R.1-73 ¶80.) The court gave specific examples of testimony by treating professionals from which the court concluded that Jacobson's opinions, based solely on the medical record, misinterpreted Ortiz's condition. (*Id.* ¶¶81-83.) The court stated, "Dr. Jacobson's conclusion that Mr. Ortiz was under an imminent risk of suicide at the VA hospital on March 18, 2003, and that the staff negligently failed to monitor him is not confirmed by the testimony at trial or by the medical records." (*Id.* ¶87.)

The court also found, "The reasons Dr. Martin gave for removing Mr. Ortiz from suicide precautions reflect

a reasonable medical assessment of Mr. Ortiz's condition and his treatment needs," (*id.* ¶86), and "Dr. Martin's decision to take Mr. Ortiz off of suicide precautions reflects a reasonable medical judgment." (*Id.* ¶91.) The order concludes, "Under the evidence presented at trial I cannot find that the VA medical staff was negligent in their care and treatment of Mr. Ortiz nor can I find that any act of the VA staff was the proximate cause of his death." (*Id.* ¶90.)

The court entered judgment for the United States. Plaintiff appeals.

II. ISSUES ON APPEAL AND CONTENTIONS OF THE PARTIES

Plaintiff argues that the district court clearly erred by not adopting Jacobson's opinion that Ortiz was suicidal and by finding that the hospital staff was not negligent and did not cause Ortiz's death. Plaintiff argues that Jacobson's testimony was the only expert testimony on the standard of care and the breach thereof and therefore should have been accepted by the district court.

The United States responds that the district court did not commit error by rejecting Plaintiff's expert witness's opinions and concluding that the hospital staff had not been negligent. The United States argues that a trier of fact may reject an expert's opinions based upon any evidence in the record, whether or not that evidence is offered by another expert witness.

III. STANDARDS OF REVIEW

We review the district court's findings of fact for clear error. *Whitley v. United States*, 170 F.3d 1061, 1068 n.14 (11th Cir. 1999) (*citing Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998). "We cannot find clear error unless 'we are left with a definite and firm conviction that a mistake has been committed.'" *United States v. Crawford*, 407 F.3d 1174, 1177 (11th Cir. 2005) (*quoting Glassroth v. Moore*, 335 F.3d 1282, 1292 (11th Cir. 2003)).

We review a district court's application of law to the facts de novo. *Whitley*, 170 F.3d at 1068 (*citing Reich v. Davis*, 50 F.3d 962, 964 (11th Cir. 1995)).

IV. DISCUSSION

In actions brought under the Federal Tort Claims Act, liability is determined under the law of the state in which the alleged negligence occurred. 28 U.S.C. § 1346(b)(1); *F.D.I.C. v. Meyer*, 510 U.S. 471, 478, 114 S. Ct. 996, 1001 (1994). Under Florida law, a hospital may be liable for the death of a inpatient who commits suicide. *Paddock v. Chacko*, 522 So.2d 410, 417 (Fla. 5th DCA 1988) ("Where a patient has surrendered himself to the custody, care and treatment of a psychiatric hospital and its staff, liability may be predicated upon the hospital's failure to take protective measures to prevent the

patient from injuring himself.") As in all medical malpractice cases,

> [T]he claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Fla. Stat. Ann. § 766.102(1).

In this case, Jacobson gave an expert opinion that the hospital staff should have recognized Ortiz was at acute risk of suicide. (R.2-81 at 47-48.) Jacobson's opinion that the hospital breached the standard of care by failing to diagnose Ortiz as suicidal was based upon his review of medical records that the VA maintained on Ortiz, including outpatient clinic, emergency room, and inpatient hospital records. (*Id.* at 48.)

The United States did not present an expert witness to opine as to the standard of care. The United States called the doctors and nursing staff members who interacted with Ortiz to explain their medical notes and

treatment of Ortiz during his March 2003 stay in the hospital. From that testimony, the district court concluded that Jacobson had misinterpreted notes in the medical record, the only information about Ortiz upon which Jacobson based his opinions. (*See* R.1-73 ¶¶80-83.) And, for that reason, the district court rejected Jacobson's expert opinion of misdiagnosis. (*Id.* ¶87 ("Dr. Jacobson's conclusion that Mr. Ortiz was under an imminent risk of suicide at the VA hospital on March 18, 2003, . . . is not confirmed by the testimony at trial or by the medical records.")).

The court did not clearly err. It was within the court's province as fact finder to conclude that Jacobson's opinion that the hospital staff breached the standard of care in failing to recognize Ortiz as suicidal should not be credited. *Mims v. United States*, 375 F.2d 135, 143 (5th Cir. 1967) ("[E]xpert opinion evidence may be rebutted by showing the incorrectness or inadequacy of the factual assumptions on which the opinion is based . . ."); [2] *Easkold v. Rhodes*, 614 So.2d 495, 497-98 (Fla. 1993) (jury may disregard a medical expert's opinion, even in the absence of expert testimony to the contrary, if it finds that the medical record upon which the expert opinion was based is incomplete); *see also* Fla. Std. Jury Instr. (Civ.) 2.2(b) ("You may accept [expert] opinion testimony, reject it, or give it the weight

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2. In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), this court adopted as binding precedent all decisions of the former Fifth Circuit handed down prior to close of business on September 30, 1981.

you think it deserves, considering the knowledge, skill, experience, training, or education of the witness, the reasons given by the witness for the opinion expressed, and all the other evidence in the case.") (emphasis added).

The other opinions Jacobson offered regarding breaches of the standard of care concern the standard of care for patients who are suicidal. Jacobson testified that the standard of care for protecting a suicidal patient "is to observe that patient frequently enough that they are not able to make [suicide] attempts . . . in a hospital." (R.2-81 at 51.) Jacobson testified that monitoring a suicidal patient at fifteen-minute increments was inadequate. (*Id.*) He also testified that a hospital has a duty to provide a safe environment, including providing an environment in which "there's no means or the means are as limited as possible to harm oneself." (R.2-81 at 54-55.) He testified that, paired with inadequate monitoring, placing a suicidal patient in a room with a window that opens so as to allow attachment of a means of hanging would be a breach of the standard of care. (R.2-81 at 55-56.)

Having rejected Jacobson's opinion that the hospital staff negligently failed to diagnose Ortiz as suicidal, the district court did not err in disregarding Jacobson's opinions that the hospital staff breached the standards of care for observation and placement of a suicidal patient. Those opinions became irrelevant once the district court determined that the hospital staff acted reasonably in concluding that Ortiz was not an acute

risk for suicide. And, the district court properly disregarded Jacobson's opinions about physical aspects of the room in which Ortiz was placed for another reason. There was no evidentiary basis for Jacobson's opinion that, when paired with monitoring at fifteen-minute intervals, placing Ortiz in a room with a window that opened was a breach of the standard of care. As stated above, there was no evidence that the window was open, only that the bed sheet with which Ortiz hung himself was attached to the top of the window.

V. CONCLUSION

The court permissibly rejected Jacobson's opinion testimony, the only evidence Plaintiff presented that the actions of the VA hospital staff breached the prevailing professional standards of care. For that reason, Plaintiff did not prove her negligence case. And, the court did not err in granting judgment to the United States.

AFFIRMED.

APPENDIX B — MEMORANDUM OF DECISION OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA, GAINESVILLE DIVISION FILED SEPTEMBER 22, 2008

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
GAINESVILLE DIVISION

Case No. 1:06-cv-255-SPM/AK

EVELYN ORTIZ, as personal Representative of the Estate of RAFAEL I. ORTIZ-PAGAN,

Plaintiff,

v.

UNITED STATES OF AMERICA,

Defendant.

MEMORANDUM OF DECISION

This wrongful death case was tried before the Court on February 25 and 26, 2008. Upon consideration of the evidence and arguments presented, the Court makes the following findings of fact and conclusions of law.

Appendix B

I. BACKGROUND

1. Rafael I. Ortiz-Pagan, an Army Veteran, committed suicide at the United States Department of Veterans Affairs Hospital (hereinafter VA hospital) located in Gainesville, Florida, on March 19, 2003, just after midnight. Mr. Ortiz's death is related to a service-connected injury that he suffered to his neck and back in a tank accident during infantry training in Colorado in 1993. The injury caused severe and disabling chronic pain with depression.

2. Mr. Ortiz is survived by his widow and the personal representative of his estate, Evelyn Ortiz, and two sons, Rafael I. Ortiz and Jose A. Ortiz.

3. Mr. Oritz retired from the military and moved with his family to Gainesville, Florida, in 1994.

4. Despite pain that affected his daily activities, Mr. Ortiz was able to maintain gainful employment for years after the accident and had a close and loving relationship with his family. He worked as a supply technician at the VA hospital in Gainesville.

5. In 1998 and 2000, Mr. Oritz had surgery to alleviate his pain. The surgeries were not successful. Mr. Oritz was unable to work from 2000 on.

6. He applied for disability with the VA. The VA awarded Mr. Ortiz 5% disability at first, but eventually acknowledged that Mr. Ortiz was entitled to 50%

disability. In 2002, Mr. Oritz applied for social security benefits, which he received the next year.

7. Despite the VA disability and social security benefits, Mr. Ortiz became depressed because he was not able to support his family.

8. Mr. Ortiz had problems regulating his medication to alleviate his pain. In July 2002 he saw VA psychologist Roger B. Fillingim. Dr. Fillingim noted that Mr. Ortiz was "very depressed about his pain condition. He has expressed suicidal ideation. He is also having nightmares about his accident that happened while he was in the service. He gets angry sometimes and his behavior is impulsive." Vol. IV[1] at 53. Dr. Fillingim noted that Mr. Ortiz last had thoughts about suicide a month before and that Mr. Ortiz denied current suicidal intent. Vol. I at 179.

9. In August 2002, Mr. Ortiz saw VA psychiatrist C. Brooks Henderson. According to Dr. Henderson's notes, Mrs. Ortiz had objected to a prescription of morphine for Mr. Ortiz because she was afraid he would take it to "sleep and never wake up." Vol. I at 174; Vol. IV at 61.

10. A psychiatry initial assessment dated August 29, 2002, noted that Mr. Ortiz had attempted suicide a few months back. Vol. IV at 69. According to the note, Mrs. Ortiz had called Dr. French at the VA hospital for

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1. Four volumes of medical records were submitted jointly by the parties as Exhibit 1.

assistance. Vol. IV at 69. He directed Mrs. Ortiz to take Mr. Ortiz to the emergency room; however, Mr. Ortiz refused treatment. Vol. IV at 69. According to the note, Mr. Ortiz reported a few attempts at suicide in the past with inadequate amounts of medications. Vol. IV at 69.

11. At times Mr. Ortiz stopped taking his pain medication, but would suffer from mood changes and uncontrollable anger.

12. The weekend before his death, Mr. Ortiz took more than his prescribed dose of pain medication. At approximately 5:00 p.m. on Friday, March 14, 2003, Rafael and Jose Ortiz, ages 19 and 16 at the time, called their mother at work to tell her that Mr. Ortiz was not responsive and that his eyes were red.

13. Mrs. Ortiz asked her sons to take the medications away from their father and to wait for her to come home.

14. Mrs. Ortiz came home ten minutes later. She found Mr. Ortiz in bed. He was unable to communicate. Mrs. Ortiz talked to him until he was able to recognize her. She had her sons move Mr. Ortiz to a seated position so she could give him food and water.

15. Mrs. Ortiz took Mr. Ortiz's medications and hid them in her car.

16. She asked him why he took so many pills. He stated that he could not handle the pain.

Appendix B

17. Mrs. Ortiz watched Mr. Ortiz throughout the night. She gave him no medications on Saturday, March 15, 2003. As time passed, he continued eating and talking, and became more responsive.

18. Sunday, March, 16, 2003, was Mrs. Ortiz's birthday. Her son Rafael brought over a birthday cake. Mr. Ortiz had forgotten his wife's birthday, which he had never done before. He apologized and stated that he had severe pain and took too many medications.

19. Mrs. Ortiz stayed with her husband all weekend, but on Monday, March 17, 2003, she returned to work and her sons left for work and school.

20. Mrs. Ortiz arranged for a friend to stay with her husband at lunchtime. The friend stayed for 4 hours.

21. Mrs. Ortiz picked up Jose from school at 3:00 p.m. and bought some items for Mr. Ortiz's bed.

22. She came home at 5:00 p.m. Mr. Ortiz was in bed and he was not responsive.

23. Jose Ortiz placed Mr. Ortiz in the shower.

24. Under the mattress, Mrs. Ortiz found medications that Mr. Ortiz had hidden.

25. Mr. Ortiz stated that no one understood his pain and he said he was sorry.

Appendix B

26. Mrs. Ortiz and Jose took Mr. Ortiz to the emergency room at the VA hospital in Gainesville at approximately 8:00 p.m.

27. Mr. Ortiz was examined by Dr. Rattana Srun, who noted that Mr. Ortiz was lethargic but able to answer questions appropriately, and that he reportedly overdosed on multiple medications. INP 47[2].

28. Mr. Ortiz told Dr. Srun "that his chronic pain had gotten to the point where he could not take it anymore and he took a bunch of pills to sleep so that he can ease the pain." INP 47.

29. Mr. Ortiz denied "that he tried to commit suicide but his son Jose stated that he witnessed him wanting to sleep and 'not wake up.'" INP 47.

30. Mr. Ortiz was kept in the emergency room overnight to monitor his heart and to allow for an evaluation by the psychiatry department in the morning. INP 45.

31. Mr. Ortiz told his wife to go home and take care of their kids. Rafael came and took Jose home so he could attend school the next morning. Mrs. Ortiz stayed at the hospital until 2 or 3 a.m. She came back around 8:00 a.m. the next morning.

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2. All references herein to INP (inpatient) records are to Volume III of the VA medical records of Mr. Ortiz.

32. At 8:39 a.m. on March 18, 2003, Mr. Ortiz was interviewed and examined by Dr. Dikea Roussos, a psychiatric resident. INP 51.

33. Mr. Ortiz complained to Dr. Roussos about "decreased sleep, energy and concentration." INP 51. He felt "hopeless and helpless since stopping work in 2000." INP 50. Mr. Ortiz denied suicidal intent and explained that he was not trying to kill himself, he just wanted the pain to go away. INP 50.

34. After speaking with Mr. Ortiz, Dr. Roussos spoke with Mrs. Ortiz. Mrs. Ortiz reported that Mr. Ortiz had received a prescription for Valium from a non-VA physician. INP 51. He had taken twenty-three tablets over a two-day period, which was more than the prescribed dose. INP 51. Mrs. Ortiz confiscated this medication, but on Monday, March 17, 2003, Mr. Ortiz had taken several more prescription pain medications, which he had hidden from Mrs. Ortiz. INP 50-51. Mrs. Ortiz reported that over the weekend, Mr. Ortiz had some hallucinations and had been in a vegetative-type state. She believed that Mr. Ortiz had taken the large dose in an attempt to alleviate his pain and not necessarily in an attempt to kill himself.

35. The VA had no history of inpatient psychiatric admission for Mr. Ortiz. However, he had been seen at the VA outpatient psychiatry clinic on several occasions because of depressive signs or symptoms. INP 50. His last visit to the VA was in November 13, 2002. INP 50. At that time, it was reported that he had taken more

than the prescribed dose of Valium on several occasions in the past but had not been admitted to the hospital. INP 50. He had not received treatment for substance abuse. INP 50.

36. Dr. Roussos diagnosed Mr. Ortiz with optiate intoxication, benzodiazepine abuse and withdrawal, major depressive disorder, and chronic pain. INP 49. As part of her diagnosis, she noted that Mr. Ortiz had "Cluster B traits" (INP 50) associated with borderline personality disorder, as evidenced by argumentative, aggressive and manipulative actions, anger, threats, and anxiety. Mr. Ortiz reported that he had "some domestic disputes where he 'pushed' his wife." INP 50. Mr. Ortiz also reported that he had panic attacks in the past related to worries about his two brothers. INP 49

37. Mr. Ortiz refused Dr. Roussos recommendation for admission to the hospital. Dr. Roussos decided to involuntarily commit him to the hospital's psychiatric ward for observation and treatment under the Florid Baker Act, Fla. Stat. § 394.465. INP 1-2. Dr. Roussos explained that she did not think Mr. Ortiz was suicidal at that time, but believed that if not admitted to the hospital he might harm himself by taking more than the prescribed dose of medication.

38. Mrs. Ortiz pleaded with Dr. Roussos not to place her husband in the psychiatric ward, which was located on the second floor. Mr. Ortiz, having previously worked for the VA hospital, understood that the second floor was the psychiatric ward. Mrs. Ortiz knew that her

husband would feel shame in being placed there. She asked Dr. Roussos if she could take Mr. Ortiz home.

39. Dr. Roussos would not allow Mrs. Ortiz to take Mr. Ortiz home, but she allowed Mrs. Ortiz to see him. Mr. Ortiz was in bed and had finished eating breakfast. He looked better and was smiling at Mrs. Ortiz.

40. Mrs. Ortiz told Mr. Ortiz that he would be staying at the hospital. When Dr. Roussos explained to him that he was being admitted to the inpatient psychiatric services, Mr. Ortiz understood that he would be taken to the second floor. Mr. Ortiz became very upset and pulled out his I.V. A Spanish-speaking nurse tried to calm him down and guards were called. Mr. Ortiz told Dr. Roussos that "you're ruining my life, you will regret sending me." INP 49.

41. Under the Baker Act, a person can be held involuntarily up to 72 hours. Dr. Roussos placed Mr. Ortiz on "suicide precautions," which requires one on one constant observation by a staff member. She placed him on this level of observation because as a resident she was required to be conservative in her approach, and Mr. Ortiz's treatment team could change the level after another evaluation. Dr. Roussos did not believe that Mr. Ortiz was suicidal. Dr. Roussos' main concern was Mr. Ortiz's safety and the need for him to be in an environment where he would not have access to medication.

42. Dr. Roussos acknowledged at trial that a box on the Baker Act form stating that "Without care or treatment said person is likely to suffer from neglect or refuse to care for himself, and such neglect or refusal poses a real and present threat of substantial harm to his well being and it is not apparent that such harm may be avoided through the help of willing family members or friends of the provision of other services," had described Mr. Ortiz's condition most accurately. INP 2. Because Dr. Roussos was not familiar with the Baker Act form, she checked the box that stated, "There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself." INP 2.

43. Mr. Ortiz was admitted to the VA hospital's inpatient psychiatric service just before noon on March 18, 2003. INP 52.

44. The medical director of the substance abuse treatment team, Dr. Camilo Martin, evaluated Mr. Ortiz at admission. He tried to gain the confidence and cooperation of Mr Ortiz, speaking to him in Spanish and in English. He confirmed the findings of Dr. Roussos.

45. Mr. Ortiz denied suicidal intent and acknowledged hoarding his medication to use more when his pain was severe. He had taken approximately 23 Valium tablets over the weekend and remained in a vegetative state, only getting out of bed to use the restroom with his wife's assistance. INP 60-61. On Monday, Mr. Ortiz took several other medications that

he had hidden from his wife. INP 60. Mrs. Ortiz spoke about her inability to cope and her need to be away from home for work.

46. Dr. Martin confronted Mr. Ortiz about the threat he made to Dr. Roussos. Mr. Ortiz explained to Dr. Martin his discomfort with staying on the second floor. He asked to leave. Mrs. Ortiz also wanted to take Mr. Ortiz home. Dr. Martin reminded Mr. Ortiz of the medication problems and explained that he needed to keep Mr. Ortiz to monitor the medications in a safe environment. Mr. and Mrs. Ortiz seemed agreeable.

47. Dr. Martin believed that Mr. Ortiz was not suicidal and had a problem adjusting his medication as his pain fluctuated. Dr. Martin testified that the number of pills taken by Mr. Ortiz was not that unusual and did not necessarily indicate that Mr. Ortiz was trying to end his life. The gradual nature of Mr. Ortiz's overdose pointed toward a pain management problem. Also, Mr. Ortiz presented himself as a man with strong religious and family values who would never inflict the pain of suicide on his wife and family.

48. Dr. Martin noted that Mr. Ortiz had an anxious mood. INP 60. His diagnosis was "Chronic pain syndrome, Substance-Induced Mood Disorder." INP 60. His plan for treatment was to admit Mr. Ortiz for immediate stabilization, to perform a routine medical work-up, and continue with the current medical/psychiatric regimen. INP 60. Dr. Martin expected that Mr. Ortiz would be released within 5 days. INP 60.

49. Later that day Dr. Martin spoke to both Mr. and Mrs. Ortiz on the ward and advised them that he was going to give a new medication to Mr. Ortiz that he believed would help him to better control his pain. Mr. Ortiz reassured Dr. Martin that he would not harm himself and would report suicidal thoughts to staff.

50. Mrs. Ortiz's sister and niece had come to the hospital. They visited with Mr. and Mrs. Ortiz. Mrs. Ortiz stayed at the hospital until about 3:00 p.m. when she went home to see Jose and Rafael.

51. According to Nurse Meffen's nursing note at 3:08 p.m., Mr. Ortiz reiterated that "'I don't take high doses of these drugs all the time.'" INP 61. Mrs. Ortiz told her that when Mr. Ortiz overdoes, he "will not get out of bed and won't eat." INP 61. Nurse Meffen explained to Mr. Ortiz that even if he did not abuse his medications all of the time, his abuse still affected others around him. INP 61.

52. Dr. Martin last saw Mr. Ortiz at 2 or 2:30 p.m. Dr. Martin removed Mr. Ortiz from suicide precautions and placed him on close observation. INP 21. Suicide precautions generally requires the patients to be constantly observed by hospital staff and stay in the day room. The change from suicide precautions to close observation meant that Mr. Ortiz would not be required to sleep in the day room with other patients, some of whom were grossly psychotic, and could wear his own clothes. Dr. Martin believed that the evidence clinically did not justify keeping Mr. Ortiz on suicide precautions.

Mr. Ortiz had consistently denied suicidal ideation. Mr. Ortiz's risk of overdose was controlled by restricting access to medications.

53. Dr. Martin believed that if he kept Mr. Ortiz on suicide precautions, Mr. Ortiz would find it disturbing to sleep in the day room with other patients. The only other sleeping option if Mr. Ortiz remained on suicide precaution was the seclusion room, which is a barren room with one mattress and cameras. The seclusion room would be difficult for Mr. Ortiz and Dr. Martin saw no indication that Mr. Ortiz needed to be kept in the seclusion room.

54. Dr. Martin testified that Mr. Ortiz's assurances that he was not planning suicide, his overall demeanor, the fact that he was not given access to his medications, his strong family ties, and the strong condemnation of suicide of Mr. Ortiz's Catholic religion, were factors in his decision not to maintain Mr. Ortiz on suicide precautions.

55. On close observation, Mr. Ortiz could stay in a regular room and wear his own clothes. Staff would check on him every 15 minutes. The medical chart (INP 76-78) documents the checks made.

56. Certified Nursing Assistant Gwendolyn Mobley observed Mr. Ortiz until 4:00 p.m. She testified that Mr. Ortiz was visiting with family. He gave no indication that he planned to commit suicide and seemed to be doing well.

57. Staff nurse Lynn Meffen, R.N, M.A., Ed.D. conducted Mr. Ortiz's initial nursing assessment at 3:41 p.m. INP 60-52. Nurse Meffen noted that Mr. Ortiz's mood and affect to be "labile, anxious and depressed." INP 55. Mr. Ortiz denied an intent to commit suicide. INP 60. He explained that the intensity of his pain varied and that he would take more than his prescribed dose of medication when his pain was severe. INP 59. Mr. Ortiz stated that his greatest concern or need was relief from intense back pain from his accident in the service. INP 52.

58. Nurse Meffen testified that she saw no need to keep Mr. Ortiz on suicide precautions. She spoke to Mr. Ortiz intermittently throughout the day until the end of her shift at 4:00 p.m.

59. Mrs. Ortiz returned to the hospital at 7:00 p.m. with Jose. She brought with her some clothing for Mr. Ortiz and a pecan pie, which Mr. Ortiz had requested earlier.

60. During their visit, Mr. Ortiz was relaxed. He was not angry. He asked Mrs. Ortiz about clothing. Mrs. Ortiz told him that she brought clothes for him, but they had been taken by the hospital guards.

61. Mr. Ortiz discussed plans to bring the family together on May 14, 2008. They would celebrate Mr. Ortiz's birthday, Mother's day, and their niece's wedding. Mr. Ortiz also joked with Jose about the other patients in the day room.

Appendix B

62. Physically, Mr. Ortiz was still feeling weak and remained in a wheel chair. Nurse Marlys Hofgren at 7:25 p.m. noted that he was able to walk short distances in the hallway. INP 52. Nurse Hofgren noted that Mr. Ortiz told her that he was not trying to hurt himself, he was just seeking pain relief. INP 52.

63. Mr. Ortiz's family stayed with him past the end of visiting hours at 8:00 p.m.

64. Nursing Assistant Deborah Henson saw Mr. Ortiz after his family left . She continued to check on Mr. Ortiz every 15 minutes. INP 78. Mr. Ortiz had a room that accommodated 3 patients, with partitions separating each bed. Mr. Ortiz had the corner bed by the window. Mr. Ortiz did nothing unusual and made no comments about wanting to commit suicide.

65. At around 9 or 9:30 in the evening, Mr. Ortiz sought out Nurse Hofgren to tell her that he was not going to hurt himself and that he did not need to be at the hospital. He asked her how he could get out. Nurse Hofgren told him that he would be evaluated in the morning. Mr. Ortiz appeared satisfied with the answer.

66. At 9:50 p.m., Mr. Ortiz refused two pain medications. INP 22.

67. Nursing Assistant Henson last saw Mr. Ortiz in bed at 11:45.

68. At 12:03 a.m., Nurse Franklin M. Larrow entered Mr. Ortiz's room on his initial round. INP 66. Mr. Ortiz appeared to be standing at the window looking out. INP 66. As Nurse Larrow approached Mr. Ortiz to introduce himself, he saw that Mr. Ortiz was hanging by a bed sheet attached to the window. INP 66. The testimony was not clear as to how the sheet was attached to the window, which required a key to open.

69. Nurse Larrow lifted Mr. Ortiz and cut the sheet. INP 66. He called staff to initiate a code. INP 66. Attempts were made to resuscitate Mr. Ortiz, but they were not successful. INP. Mr. Ortiz was pronounced dead at 12:25 a.m. on March 19, 2003. INP 67.

II. LIABILITY

70. Title 28, United States Code, Section 2674 provides that the United States is liable for the torts of its employees and agents to the same extent that a private individual is liable, except for prejudgment interest and punitive damages. The liability extends to the torts of the VA hospital, which is a federal agency. 28 U.S.C. § 2671.

71. Because the alleged negligence occurred at the VA hospital in Gainesville, Florida, substantive liability will be determined under Florida law. 28 U.S.C. § 1346(b)(1); *United States v. Muniz*, 374 U.S. 150 (1963).

72. Under Florida law, the elements of negligence are: 1) a legal duty owed by the defendant to the

plaintiff; 2) breach of the duty by the defendant; and 3) injury sustained as a proximate result of the breach. *Stahl v. Metro. Dade County,* 438 So.2d 14, 17 (Fla. 3d DCA 1983).

73. A hospital has a duty to provide a safe environment for patient care. *Paddock v. Chacko,* 522 So.2d 410, 416-17 (Fla. 5th DCA 1988). When suicide is a risk, that environment should include sufficient observations of the patient to prevent or intervene in suicide attempts; and a physical environment that removes and protects against potential methods of suicide. *Id.*

74. Plaintiff's expert, Gary Jacobson, M.D., testified that the VA hospital deviated from its standard of care by failing to watch Mr. Ortiz more closely.

75. Dr. Jacobson testified that death by hanging is the most common way that patients commit suicide in a hospital. Hanging can cause serious brain damage within 4 to 5 minutes, and death within 8 minutes. According to Dr. Jacobson, close observation at 15 minute intervals is not an adequate preventative measure.

76. Dr. Jacobson testified that the decision to commit Mr. Ortiz was correct, but the medical team placed too much emphasis on stabilizing Mr. Ortiz's pain medication and overlooked his depression, anxiety, and history of past suicide attempt.

77. Dr. Jacobson noted that Mr. Ortiz's depression was being treated with anti-depressants, but the medication would take between 5 to 14 days to take effect. According to Dr. Jacobson, until the depression was addressed, Mr. Ortiz would continue to have feelings of inadequacy from not being able to take care of his family and believe that death was the only way to free himself from his physical pain.

78. Dr. Jacobson testified that severe anxiety, as evidenced by Mr. Ortiz's history of panic attacks, was a strong risk factor for suicide. He noted that Mr. Ortiz was observed by Nurse Meffen to be labile, indicating that Mr. Ortiz could pass rapidly into an anxious state. Dr. Jacobson stated that anxiety in Mr. Ortiz could be triggered by moment-to-moment intense pain and Mr. Ortiz's discomfort from being in the psychiatric ward, particularly after visiting hours when his family went home. Dr. Jacobson testified that VA should have appreciated that the calm Mr. Ortiz demonstrated while his family was visiting was not a permanent state and that given his history of panic attacks he could pass quickly into severe anxiety.

79. Dr. Jacobson did not testify to any deficiency in the physical environment of the VA hospital that allowed for attachment of the bed sheet to the window. Instead, Dr. Jacobson's testimony focused on the failure of the VA to observe Mr. Ortiz more closely.

80. Dr. Jacobson's testimony and his conclusions about Mr. Ortiz were based entirely upon entries in the

medical records, some of which were taken out of context and which were later explained in more detail in testimony from treating psychiatrists and nurses.

81. For example, one of the first conclusions of Dr. Jacobson was that the medical entries by Dr. Roussos on March 18, 2003, indicated that Mr. Ortiz suffered from panic attacks and that this diagnosis was not carried forward into his admission and inpatient diagnosis. Dr. Roussos testified at trial that Mr. Ortiz did not have any panic attacks in the hospital and that the notation in the record about panic attacks were historical data only concerning his worries about the status of his two brothers. Dr. Roussos did not consider these worries as true panic attacks because panic attacks are not generally caused by any specific stimulus. She testified that Mr. Ortiz was not considered to be at a higher risk of suicide because of these past so called panic attacks.

82. Dr. Jacobson testified that severe subjective anxiety of which panic is an example increases the near term risk of suicide. There was no evidence presented in the record that at the time he died, Mr. Ortiz was suffering from severe anxiety. He did have some anxiety but it was not severe nor did he have a panic attack in the hospital nor in the immediate period preceding his admission.

83. Dr. Jacobson testified that the notation in the record by Nurse Meffen that on admission to the ward Mr. Ortiz's mood and affect was "Labile, Depressed and Anxious" was a factor increasing his risk of suicide in

that the patient was very unstable. INP 55. Nurse Meffen testified that she meant that Mr. Ortiz sometimes appeared depressed and other times anxious. She also stated that she did not believe he was suicidal.

84. Mr. Ortiz was observed by staff throughout the evening. Mr. Ortiz reported to Nurse Hofgren that he "is feeling better" and that "he was not trying to hurt himself when he overdosed on his medication this past weekend," but that he was only "trying to get relief from his chronic neck and back pain." INP 52. Nurse Hofgren noted that his withdrawal was "progressing safely." INP 52. She made no note about Mr. Ortiz being labile, anxious or depressed.

85. Dr Jacobson admitted that he had never seen nor spoken to Mr. Ortiz and that psychiatrists prefer to see and speak to their patients before making a diagnosis.

86. In contrast, Dr. Martin did in fact see and talk to Mr. Ortiz. The reasons Dr. Martin gave for removing Mr. Ortiz from suicide precautions reflect a reasonable medical assessment of Mr. Ortiz's condition and his treatment needs. To the extent anxiety played a role in Mr. Ortiz's death, the decision to take Mr. Ortiz off of suicide precautions was designed to lessen Mr. Ortiz's anxiety on the second floor.

87. Dr. Jacobson's conclusion that Mr. Ortiz was under an imminent risk of suicide at the VA hospital on March 18, 2003, and that the staff negligently failed to

monitor him is not confirmed by the testimony at trial or by the medical records.

88. Dr. Jacobson did not state a specific level of monitoring that he would deem appropriate for Mr. Ortiz, but his testimony suggested that observation at no more than 3-minute intervals, for a period of 5 to 14 days, was required for the VA to protect Mr. Ortiz from the risk of suicide.

89. Dr. Roussos testified if a patient is determined to commit suicide the hospital could not stop him absent locking him in a seclusion room without clothes or windows. She testified that patients in other institutions have hung themselves on door knobs.

90. Under the evidence presented at trial I cannot find that the VA medical staff was negligent in their care and treatment of Mr. Ortiz nor can I find that any act of the VA. staff was the proximate cause of his death.

91. Dr. Martin's decision to take Mr. Ortiz off of suicide precautions reflects a reasonable medical judgment.

92. The United States is not liable for Mr. Ortiz's death. The clerk shall enter judgment, with costs as provided by law, against Plaintiff and for the United States.

Appendix B

DONE AND ORDERED this 22nd day of September, 2008.

s/ Stephan P. Mickle
Stephan P. Mickle
United States District Judge

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT GRANTING PETITION FOR REHEARING EN BANC OUT OF TIME FILED FEBRUARY 1, 2010

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 08-16004-FF

EVELYN ORTIZ, as Personal Representative of the Estate of Rafael I. Ortiz-Pagan,

Plaintiff-Appellant,

versus

UNITED STATES OF AMERICA,

Defendant-Appellee.

Appeal from the United States District Court for the Northern District of Florida

ORDER:

Appellant's motion for leave to file petition for rehearing en banc out of time is granted.

s/ E.R. Cox
UNITED STATES CIRCUIT JUDGE

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DENYING PETITION FOR REHEARING EN BANC FILED MARCH 24, 2010

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-16004-FF

EVELYN ORTIZ, as Personal Representative
of the Estate of Rafael I. Ortiz-Pagan,

Plaintiff-Appellant,

versus

UNITED STATES OF AMERICA,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Florida

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

Before: BLACK, WILSON and COX, Circuit Judges.

Appendix D

PER CURIAM:

The Petition(s) for Rehearing are **DENIED** and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are **DENIED**.

s/ E.R. Cox
UNITED STATES CIRCUIT JUDGE